Arizona Health Care Cost Containment System Administration (AHCCCSA)

AHCCCS

2004–2005 External Quality Review Technical Report

For

Maricopa Acute and Long Term Care Plan

June 2005

HSAG
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Introduction

Health Services Advisory Group, Inc. (HSAG) serves as an External Quality Review Organization (EQR) for the Arizona Health Care Cost Containment System (AHCCCS). This Annual Technical Report is presented to comply with 42 CFR 438.364. The report describes the manner in which the data from activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed. This report explains the methodologies used to draw conclusions as to the quality, timeliness, and access to the care furnished by Maricopa Health Plan Acute Care and Long Term Care programs. This report includes the following for each activity conducted in accordance with 42 CFR 438.358:

i. Objectives.
ii. Technical methods of data collection and analysis.
iii. Description of data obtained.
iv. Conclusions drawn from the data.
v. The extent to which the State provided the necessary information to create this report, while safeguarding the identities of patients.

Additionally, an assessment of this managed care organization's (MCO's) strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients is included. Furthermore, recommendations for improving the quality of health care services furnished by this MCO are included. This MCO will also be assessed for the extent to which recommendations for quality improvement made the previous year (i.e., corrective action plans) have been addressed. Comparisons of the MCO's performance for quality, timeliness, access, and performance improvement are also included in this report.

In fulfilling the objectives of this report, the technical methods of data collection and analysis are presented first. The report also presents strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished. Lastly, the report presents recommendations for the State for continued quality improvement in the program.

AHCCCS's Unique Approach

AHCCCS has been held in high regard as a model program in the nation for managed care. In terms of its external quality review activities, it sets itself apart from most other states in the model it utilizes. Each state that contracts with MCOs must ensure that it has a qualified External Quality Review Organization (EQRO) perform an annual EQR for each contracting MCO. The State must ensure that the EQRO has sufficient information to use in performing the review. The information used to carry out the review must be obtained from the EQR-related activities described in 438.358 in the BBA. In addition, the information provided to the EQRO must be obtained through methods consistent with the protocols established under 438.352. In general, the majority of the Medicaid State Agencies nationwide competitively bid the mandatory activities required by the Federal

Government by seeking competent EQROs to perform these services. However, AHCCCS is unique in that it has developed the expertise and competence internally to perform the mandatory activities (Validation of performance improvement projects, Validation of MCO performance measures, Conduct a review to determine the MCO's compliance with standards).

AHCCCS has validated MCO performance and reviewed information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. AHCCCS contracts with HSAG to provide this detailed technical report. HSAG is an EQRO that meets the competence and independence requirements set forth in 438.354.

HSAG Methodology of Data Acquisition and Reporting

In February 2005, initial meetings were held with AHCCCS to discuss the EQR Technical Report Contract, and information was obtained regarding mandatory activities. HSAG reviewed the materials provided by AHCCCS and developed a Compliance With Standards Summary Tool to cross walk the voluminous data provided during the first two weeks of March 2005. Frequent meetings (at least weekly) were held with AHCCCS, both in person and on the telephone, to clarify any questions regarding the data received. A draft report outline was provided to AHCCCS as the comparative data analysis review began at the beginning of April 2005. Preliminary charts and graphs were completed by April 22, 2005, and a first draft report was provided to AHCCCS for review on April 29, 2005.

Compliance with Standards (Operational and Financial Review)

This section provides the objectives for review of the operational and financial standards and discusses the AHCCCS methodology employed to obtain the review.

Objectives for Review of Operational and Financial Review Standards

HSAG designed a Compliance with Standards Summary Tool to more easily represent the total amount of information contained within the Compliance with Standards reports submitted for Maricopa Health Plan and the Maricopa Long Term Care Plan. A paper version of this tool is attached herein as Appendix A and is available in an electronic version from HSAG. The summary tool focuses on the objectives of this analysis, which are as follows:

1. Determine the MCO's compliance with standards established by the State to comply with the requirements of 438.204(g)
2. Provide an assessment of the degree to which each MCO has addressed effectively the recommendations for improvement made by the State regarding compliance with standards
3. Provide data and results from the review of the MCO's compliance with standards that allow conclusions to be drawn as to the quality, timeliness and access to the care furnished by the MCO

AHCCCS Methodology for Review of Operational and Financial Review Standards

"Reaching across Arizona to provide comprehensive, quality health care for those in need" is the articulated mission of AHCCCS. Meeting that mission starts with AHCCCS providing each MCO with a detailed description of the expectations of the MCOs, found in the RFP solicitation. For the Compliance with Standards aspects of their responsibilities, AHCCCS supplies a detail-level tool to the MCOs.

AHCCCS reviews the operational and financial performance of each MCO throughout the year. The Agency Review Team, which is comprised of staff from the Division of Health Care Management (DHCM), the Office of Legal Assistance (OLA), and the Office of Program Integrity (OPI) perform on-site reviews by interviewing and observing operations of the MCO personnel and reviewing documentation. The review encompasses the following areas:

Maricopa Health Plan

- General Administration
- Delivery System
- Member Services
- Grievance System
- Behavioral Health
- Utilization Management
- Quality Management
- Maternal Child Health
- Financial Management
- Reinsurance
- Encounters

Maricopa Long Term Care

- Administration and Management
- Delivery System
- Member Services/Case Management
- Grievance and Appeals
- Behavioral Health
- Utilization Management
- Quality Management
- Medical Direction
- Financial Management
- Encounters

Reviews generally require three to five days, depending on the size and location of the particular MCO. The Operational and Financial Review allows AHCCCS to:

- Determine the extent to which each MCO met AHCCCS's contractual requirements, AHCCCS policies, and the Arizona Administrative Code (AAC).
- Increase AHCCCS' knowledge of each MCO's operational and financial procedures.
- Provide technical assistance and identify areas where improvements can be made, as well as identify areas of noteworthy performance and accomplishment.
- Review progress in implementing recommendations made during prior Operational and Financial Reviews.
- Determine each MCO's compliance with its own policies and evaluate the effectiveness of those policies and procedures.
- Perform MCO oversight as required by the Centers for Medicare & Medicaid Services (CMS) in accordance with the AHCCCS 1115 waiver.

An Annual Report (for each MCO) of the AHCCCS review is made by AHCCCS and the findings are sent to each MCO. In the report, each standard and sub-standard is individually listed along with a decision of the Full Compliance (FC) (the MCO is 90-100 percent compliant), Substantial Compliance (SC) (the MCO is 75 percent to 89 percent compliant), Partial Compliance (PC) (the MCO is 50 percent to 74 percent compliant), Noncompliance (NC) (the MCO is 0 percent to 49 percent compliant), or Not Applicable (NA) nature of the standard or sub-standard.

The review is sent to the MCOs with recommendations that are defined as follows:

- *The Health Plan must….* This indicates a critical noncompliance area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
- *The Health Plan should….* This indicates a noncompliance area that must be corrected to be in compliance with the AHCCCS contract but is not critical to the everyday operation of the Health Plan.
- *The Health Plan should consider….* This is a suggestion by the Review Team to improve operations of the Health Plan, although it is not directly related to contract compliance.

The MCO submits a response to each review finding with a proposed corrective action plan (CAP). AHCCCS reviews the submittal and approves all CAPS. Notably, plans have the right to appeal AHCCCS's findings.

Validation of Performance Measures

Objectives for Review of Validation of Performance Measures

AHCCCS will:

1. Assure the MCO measures and reports to the State its performance, using standard measures required by the State on an annual basis
2. Assure that validation of MCO performance measures is conducted
3. Provide the MCO with specific information on State required performance measures

Methodology for Review of Validation of Performance Measures

AHCCCS acquires and evaluates preventive health care services through performance measurement data received from its MCOs using the Health Plan Employer Data and Information Set (HEDIS®) methodology. HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA) and is a widely used and well-accepted set of performance measures.

One of the criteria used by AHCCCS to select the members included in the annual analysis is that the MCO member must have been continuously enrolled for a minimum period of time with the MCO. AHCCCS also adopted the NCQA's methodology of "rotating" measurements in order to produce a more comprehensive annual report of preventive health care services over time without the undue burden of collecting the entire measure set each year.

This rotation schedule alternates measures on a biennial basis and also affords MCOs an "intervention year" for their quality improvement efforts. By doing so, the rotating schedule gives each MCO an opportunity to focus activities on improving the specific measures that have been identified by AHCCCS as requiring attention in the annual reports. Nonetheless, two measures (i.e., Children's

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Access to Primary Care Practitioners (PCPs) and Adults' Access to Preventive/Ambulatory Health Services) are annually reported.

To acquire data, AHCCCS utilized an automated managed care data system, the Prepaid Medical Management Information System (PMMIS). MCO members included in the denominator for each measure were selected from the recipient subsystem of PMMIS. Numerators for each measure represent counts from encounter data from records of medically necessary services and related claims. AHCCCS also conducts data validation studies to evaluate the completeness, accuracy, and timeliness of encounter data. In Contract year Ending 2004 (CYE 04), AHCCCS estimated the overall accuracy of the plans' encounter data to be 85 percent.

Assessment of Performance Improvement Projects (PIPs)

Objectives for Review of PIPs

AHCCCS will:

1. Assure that each MCO has an ongoing performance improvement program of projects that focus on clinical and non-clinical areas for the services it furnishes to its enrollees
2. Assure the MCO measures performance using objective quality indicators
3. Assure the MCO conducts implementation of system interventions to achieve improvement in quality
4. Evaluate the effectiveness of the MCO's interventions
5. Assure the MCO plans and initiates activities for increasing or sustaining improvement
6. Assure the MCO reports the status and results of each project to the state in a reasonable time period to allow information on the success of performance improvement projects
7. Review annually the impact and effectiveness of each MCO's performance improvement program
8. Require that the MCO has in effect a process for its own evaluation of the impact and effectiveness of its performance improvement program

Methodology for Review of PIPs

AHCCCS requires, as part of each contract, that MCOs have an ongoing program of PIPs that focus on clinical and nonclinical areas. These projects involve the measurement of performance by using objective quality indicators, the implementation of system interventions to achieve improvements in quality, the evaluation of the effectiveness of the interventions, and the planning and initiation of activities for increasing or sustaining improvements.

The PIP reviewed for CYE 04 involved Diabetes Management Quality. Two indicators were measured: HbA1c testing and poor HbA1c control. The methodology used to measure improving HbA1c testing and the rates of poor HbA1c control among MCO members with diabetes followed HEDIS® methodologies.

The population studied included AHCCCS members diagnosed with diabetes, as defined by HEDIS® 2003. Members may be identified as a diabetic during the measurement year or within the twelve months prior to the measurement year (October 1, 2001, through September 30, 2003). Members were excluded from the study if they had a diagnosis of steroid-induced diabetes, gestational diabetes, or polycystic ovaries without two face-to-face encounters with a diagnosis of diabetes in any setting during the measurement year or prior year. Members were also excluded if they were Tribal members or fee-for-service members, due to the inability to accurately collect complete data. The population was stratified by program type, MCO, and County of enrollment.

The sample frame consisted of members 18 through 75 years of age as of September 30, 2003, who were continuously enrolled during the measurement period, with no more than one gap in enrollment of up to 31 days and diagnosed with Type 1 or Type 2 diabetes. Prior Period Coverage (PPC) was considered a break in enrollment. A change of county service area with the same MCO but without a gap in enrollment was not considered a break in enrollment.

The sample frame was identified through enrollment, claims, and encounter records, using the stated criteria. A statistical software program was used to select a representative, random sample using a 95-percent confidence level and a confidence interval of +/-5 percentage points. Based on prior studies, an oversampling rate of 10 percent was used to allow for missing or incomplete records.

Members with diabetes were identified according to HEDIS® 2003 specifications as follows: pharmacy data using the National Drug Codes (NDCs) or diagnosis codes (DRGs) with two face-to-face encounters showing different dates of service in an ambulatory or nonacute inpatient setting or in one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or the year prior to the measurement year. Two indicators were measured: HbA1c testing and poor control of HbA1c levels. HbA1c testing measured whether selected members received one or more HbA1c tests during the measurement period. Poor HbA1c control measured the degree of blood-glucose control of members. Blood glucose was considered "controlled" if the most recent HbA1c test performed during the measurement period showed a level less than or equal to 9.5 percent, as documented through automated laboratory data or medical record review.

The two measures were both quality indicator rates. The denominator for both rates was the number of MCO members in the sample whose administrative data or medical record data was examined for use in the study. The numerator for the HbA1c testing was the number of members from the denominator who had one or more HbA1c tests during the measurement period. The numerator for the poor control rate was the sum of the number of members in the denominator whose most recent HbA1c level was greater than 9.5 percent plus the number of members in the denominator who did not have the HbA1c test performed during the measurement period, considered to be in poor control by HEDIS® definition.

AHCCCS maintained confidentiality in compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements. The sample MCO member file was maintained on a secure, password-protected computer. Only AHCCCS employees who analyzed the data had access to the study data, and all employees and MCOs were required to sign a confidentiality agreement. Requested data were used only for the purpose of performing health care operations, oversight of

the health care system, or for appropriate research. Only the minimum amount of necessary information to complete the project was sent to and returned from the MCOs. Sample files given to the MCOs were tracked to ensure that all records were returned. Member names were never identified or used in reporting. Upon completion of each study, all information was removed from the computer and placed on a compact disc and stored in a secured location.

Encounters, claims, and pharmacy data (Form C) were used to identify the study population. AHCCCS established direct data links between MCOs and laboratories. These laboratories had the electronic capability to download member lab results directly into each MCO's data information system. MCOs were able to collect data directly from their data information systems. When administrative or laboratory data were not available, data were collected from members' medical or case management records – available due to the use of the HEDIS® hybrid method.

The AHCCCS Data Analysis and Research Unit (DAR) specifically developed a data collection tool for this study for the baseline, interim, and subsequent measurements. A copy of a blank tool in electronic form was provided to each MCO for optional use in collecting data. An electronic file of sample members with instructions was provided to each MCO for data entry. The final population files received by the AHCCCS Information Services Division were stratified, and the DAR Unit selected study samples. An electronic data file was prepared for each MCO. MCOs collected the required data and entered it into the electronic file. The electronic data file was then returned to AHCCCS.

MCOs were instructed in the use of the data collection tool, data collection methods, sample file layout, and timelines for data collection during a meeting with AHCCCS staff. MCOs received written instructions for data collection, in addition to AHCCCS resource and contact information for assistance. AHCCCS verified that all records were returned. The DAR Unit monitored the distribution to MCOs and the return of sample files.

To verify HbA1c levels, MCOs submitted any one of the following for each member identified as having an HbA1c test: laboratory records, pertinent medical or case management record(s), or information extracted from direct transmission of laboratory data. This documentation needed to contain a date of service and an HbA1c level. Thus, the documentation validated that an HbA1c test was performed during the measurement period. If no documentation of an HbA1c level was available, but the MCOs had evidence of a claim paid for an HbA1c test (CPT code 83036), the MCOs submitted verification of the administrative data. An electronic data validation was performed by AHCCCS by matching medical/case management records or laboratory data with data on the MCOs' electronic files.

An exclusion of women with a diagnosis of polycystic ovaries and no face-to-face encounters in any setting with the diagnosis of diabetes during the measurement year or prior year was added, according to HEDIS® 2003 criteria. These members were not excluded from the baseline measurement. MCOs were required to submit laboratory records, pertinent medical/case management record(s), electronic data directly transmitted by laboratories, or claims data for validation purposes. MCOs were not required to submit this documentation for the baseline measurement. The impact of this change would not be expected to have a large effect on the magnitude of the changes in rates from baseline to later measurements, due to the relatively small

proportion of potentially identifiable diabetic Medicaid recipients who would also fall into the excluded condition.

For the baseline measurement, MCOs were allowed to submit data via hard copy or an electronic file provided by AHCCCS. For subsequent measurement periods, MCOs were required to submit data on services to sample members via an electronic file provided by AHCCCS. Codes to identify diabetic members were updated to HEDIS® 2003. AHCCCS used NDC listings as one method to identify members with diabetes. Pharmacy data was not used to identify these members for the baseline measurement.

Dividing the earlier described numerators by the denominators formed rates for each measure. These rates were analyzed and reported by individual MCO, by urban and rural counties, and for the statewide aggregate. The median of the most recent laboratory values for all members who had an HbA1c test during the measurement period was calculated and reported separately for each MCO.

The variability of the results was characterized through the use of ranges and standard deviations. MCOs with results with more than two standard deviations from the mean were identified, and the reason was ascertained if possible. To avoid skewed and misleading conclusions, any such MCOs were considered for exclusion from selected charts and graphs. Clear documentation in the report delineated MCO exclusions and the reasons for these exclusions. Differences between the baseline study results and this remeasurement time period were analyzed for relative change and for their statistical significance. The results of the study were compared to the results of other state Medicaid programs as reported by NCQA. Results for urban and rural counties were compared. Individual MCOs were also compared to each other and to the statewide average. All other stratifications as deemed appropriate (i.e., age, gender) were compared with each other.

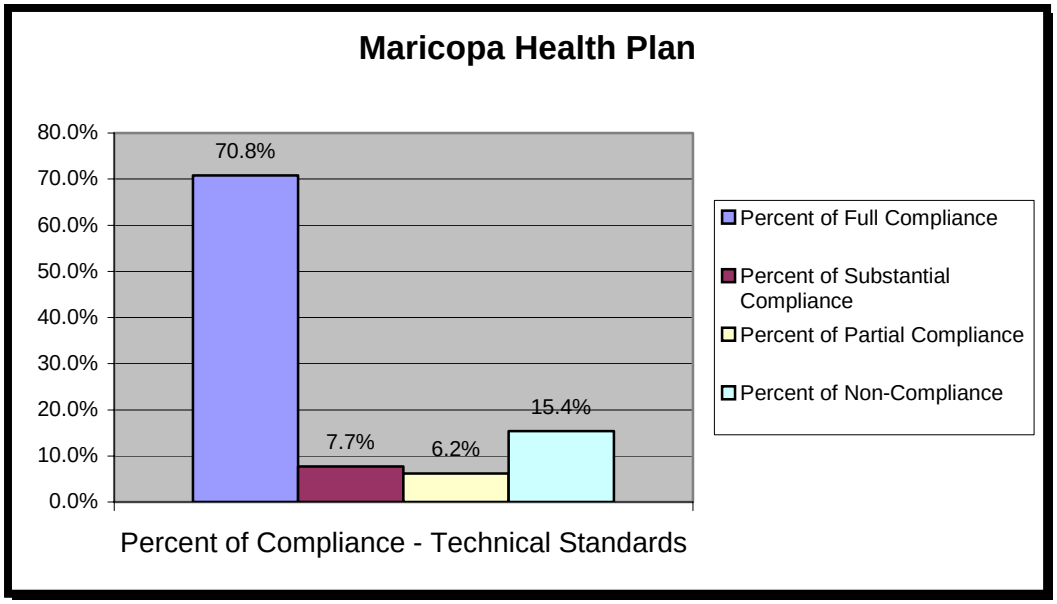
Maricopa Health Plan Findings

Section 3 separately presents the data for Maricopa Health Plan and Maricopa Long Term Care. First, a graph of the results of the Compliance with Standards is presented, followed by both a table and a graph depicting the current state of the Performance Measures (i.e., HEDIS®). Lastly, two graphs are presented of the current state and change status of the Performance Improvement Projects.

Compliance with Standards (Operational and Financial Review)

Figure 3-1 shows Maricopa Health Plan's percentage of compliance with AHCCCS Selected standards for CYE 04.

Figure 3-1—Compliance with Technical Standards *for* Maricopa Health Plan



The difference between at least partial compliance and full compliance (84.7 percent- 70.8 percent = 13.9 percent) represents a scenario whereby the plan seems to know the intent of the Standard but is not fully achieving it. This scenario stands in contrast to the 15.4 percent noncompliance, where the plan might not understand even the intent of the Standard. In the first case (i.e., understanding but not fully achieving the Standard) the plan might make large strides in accomplishing full compliance with relatively little effort, as compared with the educational and other activities that might be required to move a standard from noncompliance to full compliance.

Corrective Action Plans for Compliance with Standards

Table 3-1 details the AHCCCS selected standards for which Maricopa Health Plan was cited to perform a corrective action plan (CAP). The CAPs clustered within the areas of Delivery System, Quality Management, Grievance System and Utilization Management Standards.

Table 3-1—Corrective Action Plan (CAP) Overview *for* Maricopa Health Plan

Category	Number of Selected Subsections Cited for Corrective Action Plans
General Administration	0
Delivery System	4
Member Services	0
Grievance System	2
Utilization Management	2
Quality Management	3
Financial Management	0
Total	**11**

Performance Measure Review

Table 3-2 represents Maricopa Health Plan's results for its Performance Measurement Programs. Of the five Performance Measures captured in this report, Maricopa Health Plan failed to meet the CYE 04 Minimum AHCCCS Performance Standard for three of them (60 percent not meeting the Standard). Only Breast Cancer Screening and Timeliness of Prenatal Care met or exceeded the AHCCCS Performance Standard.

Table 3-2—Performance Measurement Programs *for* Maricopa Health Plan

Performance Indicator	Actual Performance for Previous Remeasurement Period*	Actual Performance for Oct. 1, 2002 to Sept. 30, 2003	Significance Level	CYE 04 Minimum AHCCCS Performance Standard	CYE 04 Corrective Action Plan Required
Children's Access to PCPs	66.1%	52.7%	$p < .001$	77.0%	Yes
Cervical Cancer Screening (3-year period)	37.3%	44.1%	$p < .001$	57.0%	Yes
Breast Cancer Screening	51.5%	60.2%	$p = .009$	55.0%	No
Adult Ambulatory/ Preventive Care	70.7%	63.2%	$p < .001$	78.0%	Yes
Timeliness of Prenatal Care	NA	60.3%	NA	59.0%	No

*Remeasurement Periods Differ Between Performance Indicators

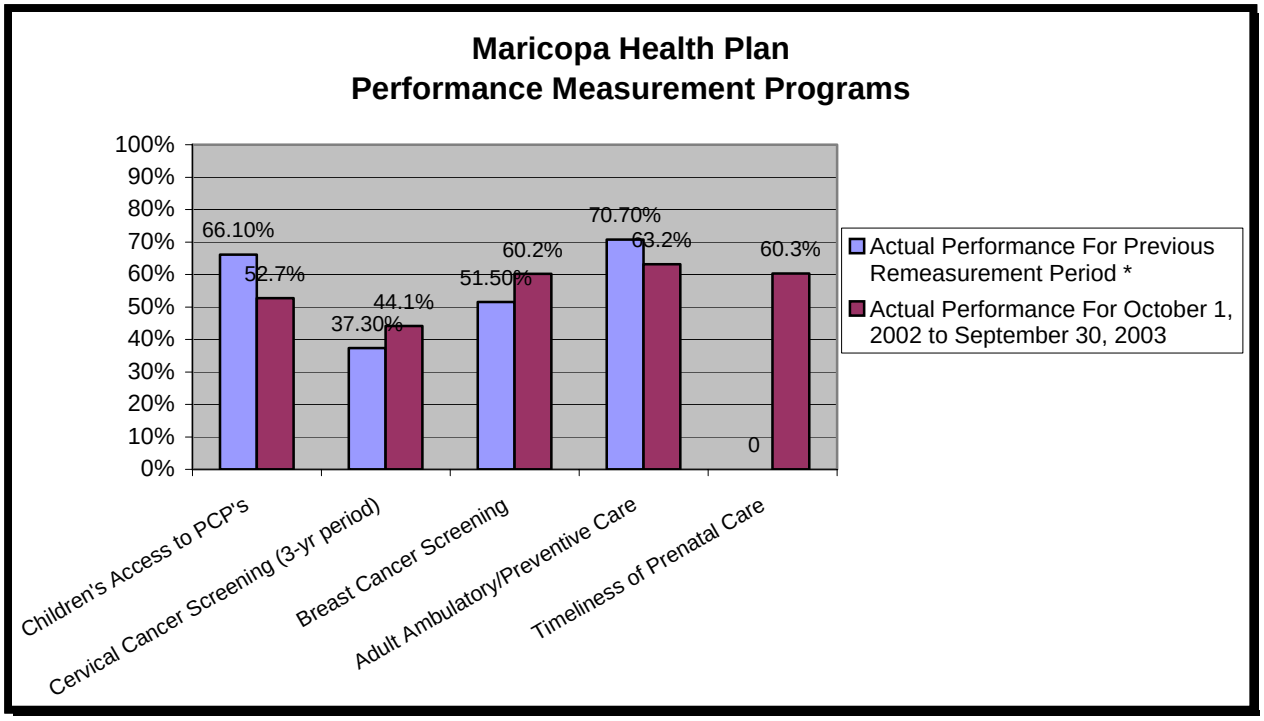
NA = Not Applicable

Performance Measures—Corrective Action Plan

As shown in Table 3-2, Maricopa Health Plan met two of the five State-required performance indicators and consequently corrective action plans were initiated.

Figure 3-2 shows Maricopa Health plan has made very little improvement from the previous measurement period to the most current one. Two of the four measures with data for both time periods have decreased and two have increased. The measure that has only current data, Timeliness of Prenatal Care, is also one of the measures that met or exceeded the State's Minimum Performance Standard.

Figure 3-2—Performance Measurement Programs *for* Maricopa Health Plan



Review of Performance Improvement Projects

Table 3-3 and Figure 3-3 show that the performance between baseline and remeasurement for Maricopa Health Plan's quality indicator rates for HbA1c testing is remarkable. The baseline indicator of 81.6 percent and the current indicator rate of 83.6 percent are substantively high, indicating substantial sustained effort on the part of the plan.

Table 3-3—Performance Improvement Project—HbA1c Testing *for* Maricopa Health Plan (Acute Care)

Contractor	Baseline HbA1c	HbA1c First Remeasurement	Relative Change	Significance Level
Maricopa Health Plan	81.6 %	83.6 %	2.5 %	p = .542

Figure 3-3—Acute Care Testing *for* Maricopa Health Plan

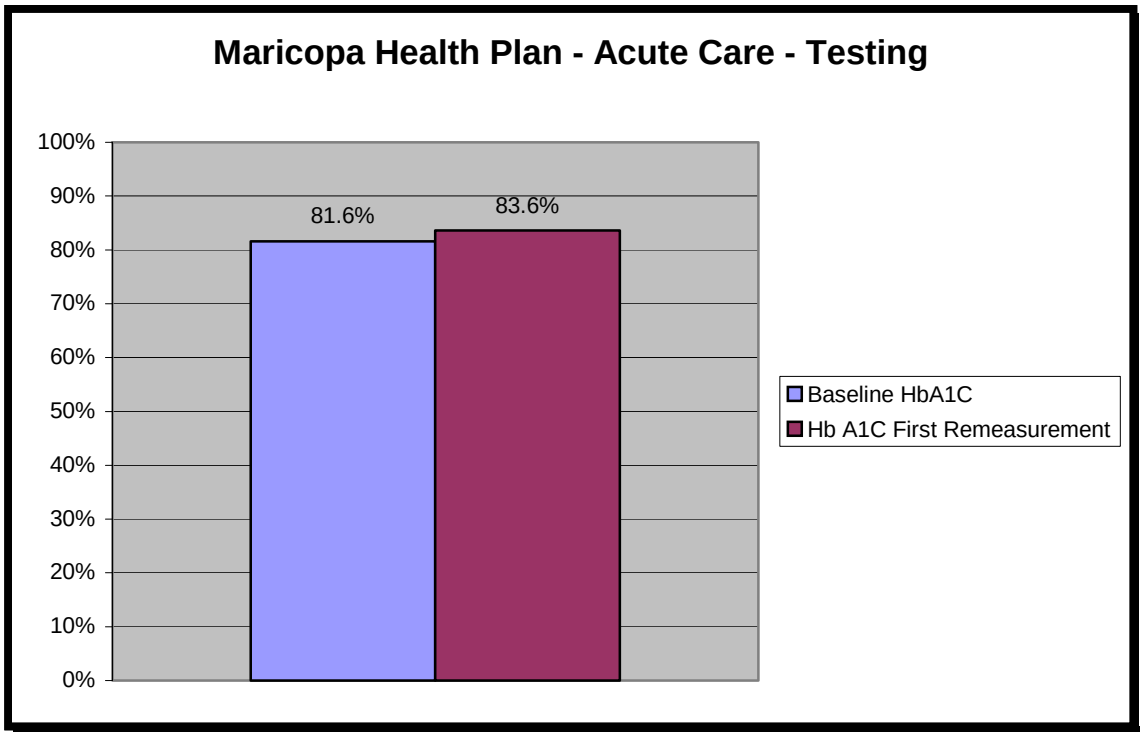
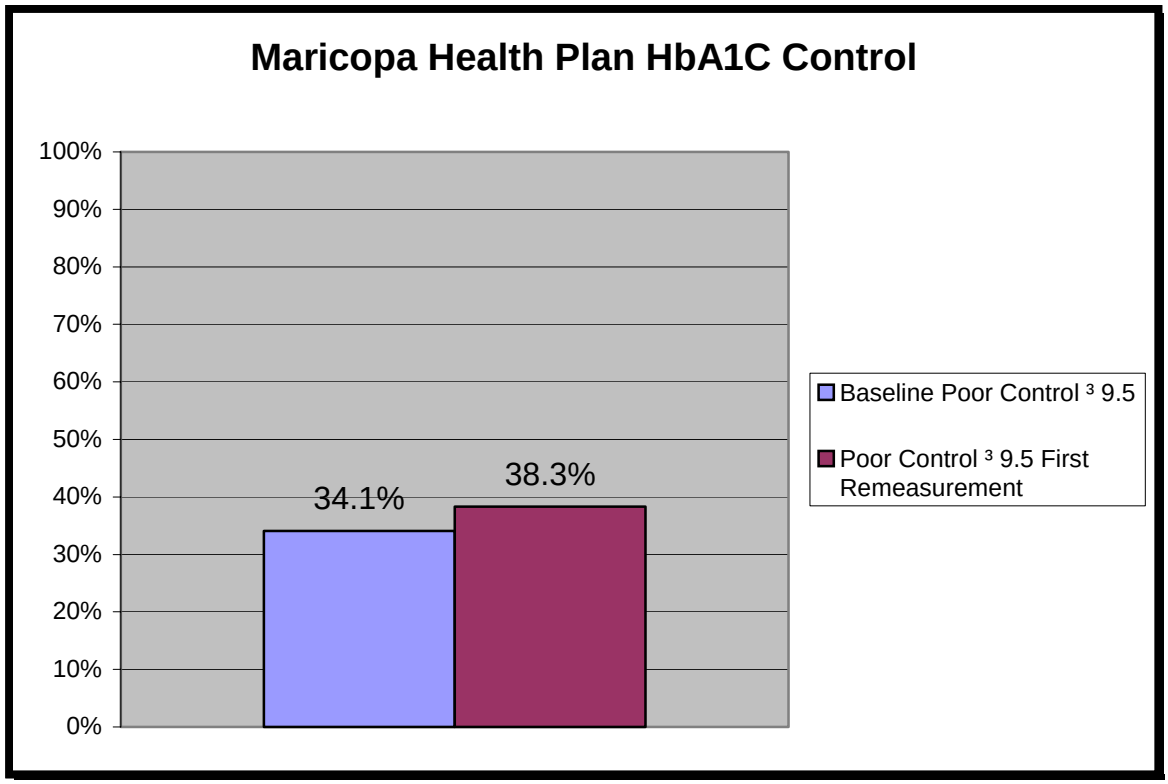


Table 3-4 and Figure 3-4 present the results from the second diabetes indicator, poor HbA1c control. The graph shows that members in poor control actually increased from 34.1 percent to 38.3 percent. This represents that well over one-third of the population with diabetes remain in poor control. This data presents the health plan with an opportunity to review and renew its efforts in terms of diabetes management. Such an effort might help reduce the number of patients whose diabetes is poorly controlled.

Table 3-4—Performance Improvement Project—HbA1c Control *for* Maricopa Health Plan

Contractor	Baseline Poor Control > 9.5	Poor Control > 9.5 First Remeasurement	Relative Change	Significance Level	Median HbA1c Level First Remeasurement
Maricopa Health Plan	34.1 %	38.3 %	12.3 %	p = .311	7.9

Figure 3-4—HbA1c Control *for* Maricopa Health Plan



Performance Improvement Projects—Corrective Action Plan

AHCCCS requires that this MCO must, at a minimum, maintain this level of performance to demonstrate sustained improvement in the second remeasurement period. A report detailing PIP interventions and strategies to achieve sustained improvement is to be submitted to AHCCCS.

Strengths and Weaknesses for Maricopa Health Plan—Acute Care

The next three sections discuss any apparent strengths or weaknesses in meeting the State's requirements or other expectations for Compliance with Standards, Performance Measures, and Performance Improvement Projects, following a brief review of the results presented earlier in each section. Each section will also contain recommendations for the plan, if any. Overall programmatic strengths and weaknesses for each section are discussed later in the report when the overall results are presented, along with any recommendations.

Compliance with Standards (Operational and Financial Review)

With 70.8 percent of the Standards fully compliant and another 13.9 percent at least partially compliant, Maricopa Health Plan seems to understand the intent behind 84.7 percent of the selected Standards. The current challenge at this point in time for Maricopa Health Plan is to improve educational and other efforts to train the necessary personnel on 15.4 percent of the selected Standards for which they are noncompliant.

Furthermore, Maricopa Health Plan can review methodologies to improve on the 13.9 percent of the selected Standards for which they were at least in partial compliance but not in full compliance. This would make them fully compliant with all 84.7 percent of the standards where they are now at least in partial compliance, or better.

Areas of true strengths regarding compliance with standards include General Administration, Member Services, and Financial Management, as indicated by the plan's full compliance with the standards. Areas of identified weakness are indicated by noncompliance. Noncompliance was noted in the area of Delivery Services, as Maricopa Health Plan failed to meet the minimum network standards for pharmacies in GSA 12 and failed to submit a Provider Affiliation Transmission (PAT) to AHCCCS by the 15th day of each quarter. In the area of Utilization Management, Maricopa Health Plan failed to implement written policies and procedures for utilization management program requirements, which are consistent with AHCCCS standards, and failed to have mechanisms in place to detect and address potential under-utilization issues. AHCCCS approved specific corrective action plans to remedy these areas of noncompliance.

Performance Measure Review

As stated earlier, just two of five measures (40 percent) met or exceeded the CYE 04 Minimum AHCCCS Performance Standard: Timeliness of Prenatal Care and Breast Cancer Screening. Not only did the other three measures (60 percent) fail to meet the CYE 04 Minimum AHCCS Performance Standard, two of the three performance measures were worse than the previous measurement and the third measurement showed very little overall progress from the previous measurement time period. The challenge for Maricopa Health Plan is more the limited progress seen from baseline to the most recent remeasurement than it is of not meeting the standards, per se. Improvement is a continual, albeit sometimes gradual, process. Nonetheless, improvement requires movement in the measurements rates that is positive and sustained over time, something not yet seen for the performance measures for this plan.

Review of Performance Improvement Projects

HbA1c testing rate changes for Maricopa Health Plan were 81.6 percent to 83.6 percent. Maricopa Health Plan's quality indicator rates for HbA1c testing are remarkable. The baseline indicator of 81.6 percent and the current indicator rate of 83.6 percent are substantively high, indicating substantial sustained effort on the part of the plan to test health plan members.

The results from the second diabetes indicator, poor HbA1c control, show members in poor control actually increased from 34.1 percent to 38.3 percent. This represents that well over one-third of the population with diabetes remain in poor control. This data presents the health plan with an opportunity to review and renew its efforts in terms of diabetes management. Such an effort might help reduce the number of patients whose diabetes is poorly controlled.

Recommendations for Maricopa Health Plan

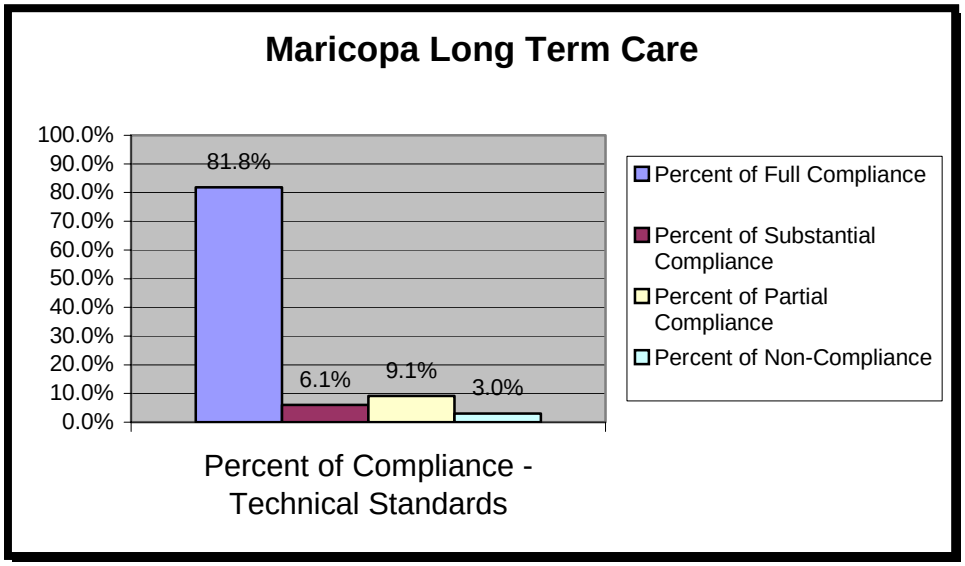
Overall, and as seen from the data, tables, and graphs presented herein, Maricopa Health Plan is presented with several opportunities for quality improvement. Maricopa Health Plan is responsible for addressing opportunities for quality improvement through the corrective action plan process established by AHCCCS. Although the plan is empowered to design and implement a corrective action plan that most suitably addresses substandard performance, AHCCCS has the authority to approve or disapprove the corrective action plan. It will be imperative that Maricopa Health Plan follow completely through with its corrective action plan(s) already approved by AHCCCS, which will also be monitored by AHCCCS.

Maricopa Long Term Care Findings

Compliance with Standards (Operational and Financial Review)

Figure 3-5 shows Maricopa Long Term Care Plan's percentage of compliance with the technical standards in its contract.

Figure 3-5—Compliance with Technical Standards *for* Maricopa Long Term Care



The difference between at least partial compliance and full compliance (97 percent - 81.8 percent = 15.2 percent) represents a scenario whereby the plan clearly seems to know the intent of the selected Standards and is close to fully achieving it. This scenario stands in contrast to the 3 percent noncompliance, where the plan might not understand even the intent of the Standard. In the first case (i.e., understanding but not fully achieving the Standard) the plan might make large strides in accomplishing full compliance with relatively little effort, as compared with the educational and other activities that might be required to move a standard from noncompliance to full compliance.

Corrective Action Plans for Compliance with Standards

Table 3-5 details the seven AHCCCS selected standards for which Maricopa Long Term Care was cited to perform a corrective action plan. The CAPs showed no specific clustering. Citations were given in the Administration and Management, Behavioral Health, Financial Management, Grievance and Appeals, Quality Management, and Utilization Management Standards.

Table 3-5—Corrective Action Plan (CAP) Overview *for* Maricopa Long Term Care

Category	Number of Corrective Action Plans
Administration and Management	2
Behavioral Health	1
Delivery System	0
Financial Management	1
Grievance and Appeals	1
Quality Management	1
Utilization Management	1
Medical Direction	0
Total	**7**

Performance Measure Review

Table 3-6 and Figure 3-6 represent Maricopa Long Term Care Plan's results for its Performance Measurement Programs.

Table 3-6—Performance Measurement Programs *for* Maricopa Long Term Care

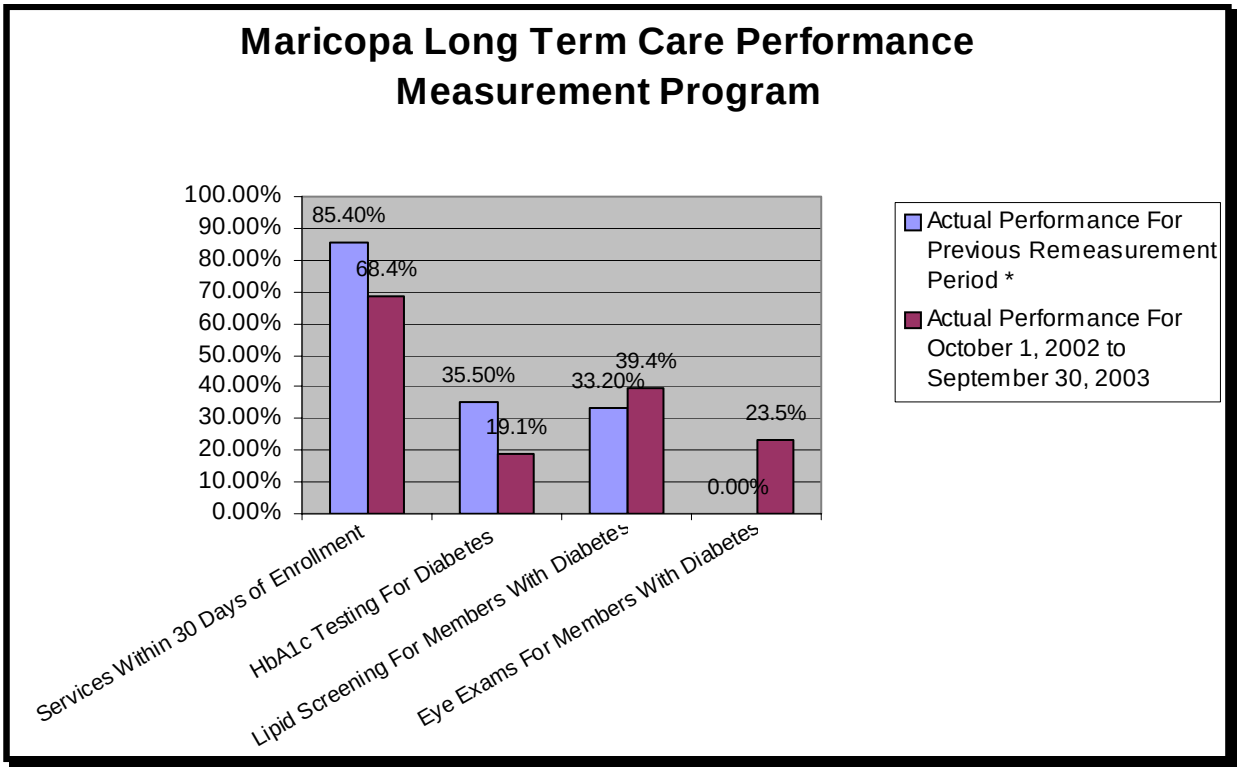
Performance Indicator	Actual Performance for Previous Remeasurement Period*	Actual Performance for Oct. 1, 2002 to Sept. 30, 2003	Relative Percent Change From Previous Period	Significance Level	Met AHCCCS Minimum Performance Standard
Services Within 30 Days of Enrollment	85.4 %	68.4 %	-19.9 %	p = .012	No
HbA1c Testing for Diabetes	35.5 %	19.1 %	-46.2 %	p < .001	No
Lipid Screening for Members With Diabetes	33.2 %	39.4 %	18.7 %	p = .015	No
Eye Exams for Members With Diabetes	NA	23.5 %	NA	NA	No

*Remeasurement Periods Differ Between Performance Indicators
NA= Not Applicable

Of the four Performance Measures captured in this report, Maricopa Long Term Care Plan failed to meet the CYE 04 Minimum AHCCCS Performance Standard for 100 percent of them. Additionally, of the three programs that had previous measurements, two of them showed significant reductions in success. Only Lipid Screening for Members with Diabetes showed an improvement.

Figure 3-6 visually highlights the significant decline in performance for two of the five indicators. Such dramatic changes suggest possible documentation errors or significant system errors that need correction.

Figure 3-6—Performance Measurement Programs *for* Maricopa Long Term Care



Performance Measures—Corrective Action Plan

AHCCCS initiated mandatory corrective action plans for Maricopa Long Term Care. Analysis of the data found significant documentation issues within the MCO. Corrective Action Plans were submitted to AHCCCS by Maricopa Long Term Care and were approved for implementation.

Review of Performance Improvement Projects

Table 3-7 and Figure 3-7 demonstrate that the change in performance between baseline and remeasurement for Maricopa Long Term Care Plan's quality indicator rates for HbA1c testing is remarkable. The measurement improved over a previously good result. The current indicator rate of 79.7 percent is statistically significant and indicative of substantial effort on the part of the plan.

Table 3-7—Performance Improvement Project—HbA1c Testing *for* Maricopa Long Term Care

Contractor	Baseline HbA1c	HbA1c First Remeasurement	Relative Change	Significance Level
Maricopa Long Term Care	63.6 %	79.7 %	25.3 %	p < .001

Figure 3-7— HbA1c Testing *for* Maricopa Long Term Care

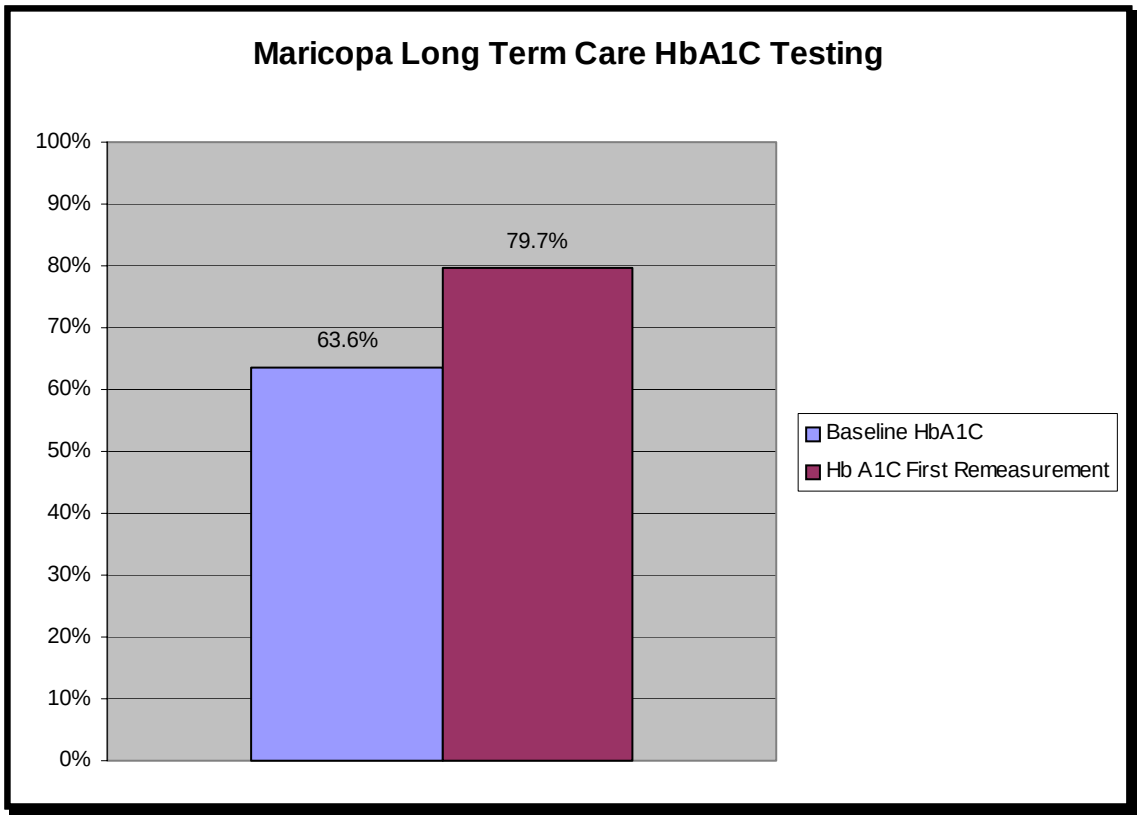
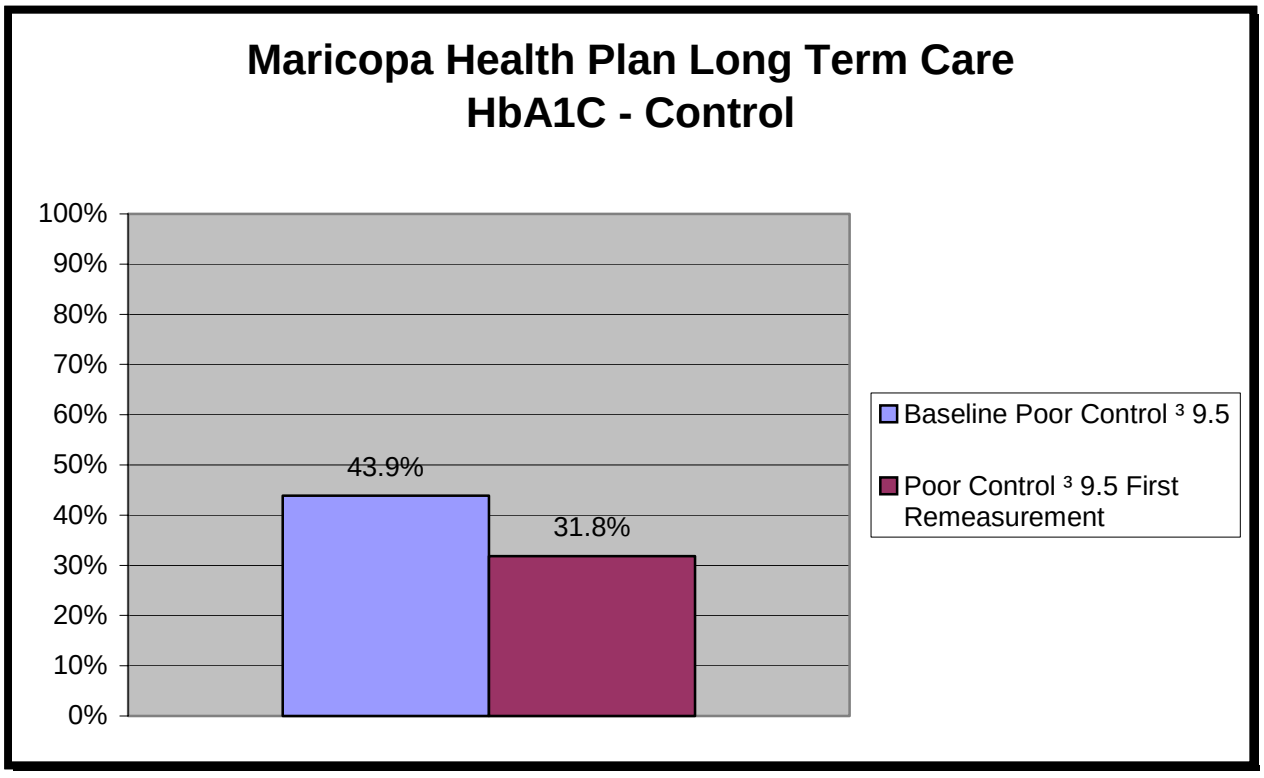


Table 3-8 and Figure 3-8 present the results from the second diabetes indicator, poor HbA1c control. They show that members in poor control decreased from 43.9 percent to 31.8 percent—a successful result. While an improvement has in fact occurred, there is still almost one-third of the population with diabetes in poor control. This data presents the health plan with an opportunity to review its efforts in terms of diabetes management. Such an effort might help reduce the number of patients whose diabetes is poorly controlled.

Table 3-8—Performance Improvement Project—HbA1c Control *for* Maricopa Long Term Care

Contractor	Baseline Poor Control > 9.5	Poor Control > 9.5 First Remeasurement	Relative Change	Significance Level
Maricopa Long Term Care	43.9%	31.8%	-27.6%	p = .007

Figure 3-8— HbA1c Control *for* Maricopa Long Term Care



Performance Improvement Projects - Corrective Action Plan

AHCCCS requires that this MCO must, at a minimum, maintain this level of performance to demonstrate sustained improvement in the second remeasurement period. A report detailing PIP interventions and strategies to achieve sustained improvement is to be submitted to AHCCCS.

Strengths and Weaknesses for Maricopa Long Term Care

The next three sections discuss any apparent strengths or weaknesses in meeting the State's requirements or other expectations for Compliance with Standards, Performance Measures, and Performance Improvement Projects, following a brief review of the results presented earlier in each section. Each section will also contain recommendations for the plan, if any. Overall results are presented, along with any recommendations.

Compliance with Standards (Operational and Financial Review)

With 81.8 percent of the selected Standards fully compliant and another 15.2 percent at least partially compliant, Maricopa Long Term Care Plan seems to understand the intent behind 97 percent of the selected Standards. The current challenge at this point in time might be for Maricopa Long Term Care Plan to improve on the 15.2 percent of the selected Standards for which it was at least in partial compliance but not in full compliance. This would allow Maricopa Long Term Care to be fully compliant with all 97 percent of the Standards where they are now at least in partial compliance, or better. Furthermore, educational and other efforts should commence to train the necessary personnel on the 3 percent of the selected Standards for which they are noncompliant.

Areas of true strengths regarding compliance with standards include Delivery System and Medical Direction, as indicated by the plan's full compliance with the standards. Areas of identified weakness are indicated by noncompliance. Specifically, in the area of Behavioral Health, Maricopa Long Term Care Plan failed to ensure that covered behavioral health services were provided in a timely manner. Maricopa Long Term Care Plan does not monitor to ensure that behavioral health services are provided in coordination with the member's primary care physician and in coordination with other involved agencies and parties. Maricopa Long Term Care Plan must monitor and evaluate its provider compliance with emergent and routine appointment standards. AHCCCS approved a specific corrective action plan to remedy these areas of noncompliance.

Performance Measure Review

As stated earlier, all four measures (100 percent) failed to meet the CYE 04 Minimum AHCCCS Performance Standard. Additionally, of the three programs that had previous measurements, two of them showed significant reductions in success. Only Lipid Screening for Members with Diabetes showed an improvement. The challenge for Maricopa Long Term Care Plan is more the lack of progress seen from baseline to the most recent remeasurement than it is of not meeting the standards, per se. Improvement is a continual, albeit sometimes gradual, process. Nonetheless, improvement requires movement in the measurement rates in that is positive and sustained over time, something not yet seen for the performance measures for this plan.

Review of Performance Improvement Projects

The HbA1c testing rates move from 63.6 percent to 79.7 percent along with improvement in the reduction of members with poor control of HbA1c (decreased from 43.9 percent to 31.8 percent) is a clear strength of the Maricopa Long Term Care Plan and indicates continued efforts to achieve quality care. While an improvement has in fact occurred, there is still almost one-third of the population with diabetes in poor control. This data presents the health plan with an opportunity to

review its efforts in terms of diabetes management. Such an effort might help reduce the number of patients whose diabetes is poorly controlled.

Recommendations for Maricopa Long Term Care

Overall, and as shown in the data, tables, and graphs presented herein, Maricopa Long Term Care Plan is presented with several opportunities for quality improvement. Maricopa Long Term Care Plan is responsible for addressing opportunities for quality improvement through the corrective action plan process established by AHCCCS. Although the plan is empowered to design and implement a corrective action plan that most suitably addresses substandard performance, AHCCCS has the authority to approve or disapprove the corrective action plan. It will be imperative that Maricopa Long Term Care Plan follow completely through with its corrective action plan(s) already approved by AHCCCS, which will also be monitored by AHCCCS.

Maricopa Health Plan

In CYE 04, the following areas were selected by AHCCCS for review.

Table A-1—Areas of Review *for* Maricopa Health Plan	
Number	**Description**
General Administration	
CC/LEP 1.1	Interpretation services are available at the Health Plan.
CC/LEP 1.2	The Health Plan ensures that interpreter services are available at provider appointments.
CC/LEP 1.3	The Health Plan seeks feedback from members on the availability of interpreters.
CC/LEP 2.1	The Health Plan translates all member materials into prevalent languages.
CC/LEP 2.2	The Health Plan uses a communications method, other than the member handbook, to notify members that information and materials are available in other languages.
CC/LEP 3.1	The Health Plan maintains a cultural competency-training program.
CC/LEP 3.2	The Health Plan has a provider education program about culturally competent services.
CC/LEP 3.3	The Health Plan assesses the cultural competency of the provider network.
CC/LEP 3.4	The Health Plan ensures that members are aware of its rights to culturally competent materials and services.
CC/LEP 3.5	The Health Plan assesses complaints and requests for provider changes for cultural competency/limited English proficiency needs or issues.
Delivery System	
DS 1.1	The Health Plan meets the minimum network standards for hospitals in GSA 2.
DS 1.2	The Health Plan meets the minimum network standards for hospitals in GSA 4.
DS 1.3	The Health Plan meets the minimum network standards for hospitals in GSA 6.
DS 1.4	The Health Plan meets the minimum network standards hospitals in GSA 8.
DS 1.5	The Health Plan meets the minimum network standards for hospitals in GSA 10.
DS 1.6	The Health Plan meets the minimum network standards for hospitals in GSA 12.
DS 1.7	The Health Plan meets the minimum network standards for hospitals in GSA 14.
DS 1.8	The Health Plan meets the minimum network standards for primary care providers in GSA 2.
DS 1.9	The Health Plan meets the minimum network standards for primary care providers in GSA 4.
DS 1.10	The Health Plan meets the minimum network standards for primary care providers in GSA 6.
DS 1.11	The Health Plan meets the minimum network standards for primary care providers in GSA 8.
DS 1.12	The Health Plan meets the minimum network standards for primary care providers in GSA 10.

Table A-1—Areas of Review *for* Maricopa Health Plan	
Number	**Description**
Delivery System—continued	
DS 1.13	The Health Plan meets the minimum network standards for primary care providers in GSA 12.
DS 1.14	The Health Plan meets the minimum network standards for primary care providers in GSA 14.
DS 1.15	The Health Plan meets the minimum network standards for dentists in GSA 2.
DS 1.16	The Health Plan meets the minimum network standards for dentists in GSA 4.
DS 1.17	The Health Plan meets the minimum network standards for dentists in GSA 6.
DS 1.18	The Health Plan meets the minimum network standards for dentists in GSA 8.
DS 1.19	The Health Plan meets the minimum network standards for dentists in GSA 10.
DS 1.20	The Health Plan meets the minimum network standards for dentists in GSA 12.
DS 1.21	The Health Plan meets the minimum network standards for dentists in GSA 14.
DS 1.22	The Health Plan meets the minimum network standards for pharmacies in GSA 2.
DS 1.23	The Health Plan meets the minimum network standards for pharmacies n GSA 4.
DS 1.24	The Health Plan meets the minimum network standards for pharmacies in GSA 6.
DS 1.25	The Health Plan meets the minimum network standards for pharmacies in GSA 8.
DS 1.26	The Health Plan meets the minimum network standards for pharmacies in GSA 10.
DS 1.27	The Health Plan meets the minimum network standards for pharmacies in GSA 12.
DS 1.28	The Health Plan meets the minimum network standards for pharmacies in GSA 14.
DS 1.29	The Health Plan has a system in place to assess the adequacy of the network.
DS 1.30	The Health Plan submits a Provider Affiliation Transmission (PAT) to AHCCCS by the 15th day of each quarter.
DS 1.31	The Health Plan monitors those entities to which it delegates network development and/or management functions.
Member Services	
MS 1.1	All materials in the packet have been approved by the Administration.
MS 1.2	The packet includes a PCP assignment letter.
MS 1.3	Instructions about changing PCPs are in the packet.
MS 1.4	The packet includes a comprehensive provider listing.
MS 1.5	A member handbook is included in the New Member Information packet.

Table A-1—Areas of Review *for* Maricopa Health Plan	
Number	**Description**
Grievance System	
GS 1.1	Written acknowledgement of provider grievances and member appeals is timely sent.
GS 1.2	Written decisions are issued no later than 30 days from claim dispute.
GS 1.3	When an extension is agreed to, the decision is issued within a reasonable time frame.
GS 1.4	Written expedited decisions are issued no later than three days from receipt of appeal.
GS 1.5	Extensions for expedited cases shall not exceed 14 days.
GS 2.1	Each appeal or claim dispute is thoroughly investigated using the applicable statutory, regulatory, and contractual provisions, as well as the Health Plan's policies and procedures.
GS 2.2	Individuals who make decisions about appeals were not involved in the previous level of review or decision.
GS 2.3	The Health Plan provides reasonable assistance to enrollees in completing forms and taking procedural steps.
GS 2.4	Enrollees are provided an opportunity to examine their case file and to present evidence.
GS 3.1	Grievance logs are maintained and identify the grievant, date of receipt, nature of the appeal, the date the issue is resolved, and the resolution.
GS 3.2	The Health Plan uses the AHCCCS decisions that have been found in favor of the Complainant to improve its processes.
GS 4.1	The Health Plan has policies that comply with AHCCCS contract requirements.
GS 4.2	The Health Plan's new employees receive training about grievance system policy and procedures.
GS 5.1	The Health Plan completes and submits a quarterly grievance report to the AHCCCS Administration (AHCCCSA).
Utilization Management	
UM 1.1	The Health Plan has implemented written policies and procedures for utilization management program requirements, which are consistent with AHCCCS standards.
UM 1.2	Mechanisms are in place to detect and address potential under-utilization issues.
UM 1.3	Mechanisms are in place to detect and address potential over-utilization issues.
UM 1.4	The Health Plan has adopted and disseminated practice guidelines.
PA 1.1	The Health Plan has a structure and process in place to monitor/evaluate prior authorization services.
PA 1.2	The Health Plan makes prior authorization decisions in a timely manner.
PA 1.3	The Health Plan monitors summary information that describes the cost and utilization of pharmacy services to allow the Health Plan to adequately manage its prescription benefit program.

Table A-1—Areas of Review *for* Maricopa Health Plan	
Number	**Description**
Quality Management	
QM 1.1	The Health Plan's peer review process is clearly defined.
QM 2.1	The Quality Management/Quality Improvement (QM/QI) Program has components that incorporate care coordination.
QM 3.1	The Health Plan has a system in place for credentialing providers included in its contracted service provider network.
QM 3.2	The Health Plan has a system in place for recredentialing providers included in its contracted service provider network.
QM 3.3	The Health Plan has a process that ensures written policies reflect the scope, criteria, timeliness, and process for credentialing and recredentialing practitioners and organizational providers.
QM 4.1	The Health Plan has a process for reviewing and evaluating quality-of-care complaints and allegations.
QM 4.2	The Health Plan has developed and implemented processes for resolving issues raised by enrolled members and contracted providers.
QM 5.1	The Health Plan QM/QI Program measures and reports the performance of the Health Plan using standard performance indicators established or adopted by AHCCCS.
QM 6.1	The Health Plan conducts performance improvement projects to assess the quality of its service provision and to improve performance.
QM 7.1	The Health Plan must submit required initial and interim reports to AHCCCS for approved extra credit activities.
Financial Management	
FM 1.1	The Health Plan has written policies and procedures for coordination of benefits and third-party liability, which it follows.
FM 1.2	The Health Plan reports third-party liability to AHCCCS within 10 days of receipt of knowledge of a third-party payer.

Maricopa Long Term Care

In CYE 04, the following areas were selected by AHCCCS for review.

Table A-2—Areas of Review *for* Maricopa Long Term Care	
Number	**Description**
Administration and Management	
AM 1.1	The Program Contractor monitors its prior authorization staff and its case managers to ensure that member rights and responsibilities notification requirements are met.
AM 1.2	Members are notified in a timely manner of their rights and responsibilities when there is a denial of a service requiring authorization.
AM 1.3	Members are notified in a timely manner of their rights and responsibilities when there is a reduction, suspension, or termination of a home and community-based setting (HCBS) service requiring authorization.
AM 1.4	The "Notice of Intended Action" forms give a specific reason for the intended action.
AM 1.5	The "Notice of Intended Action" forms give a specific reason for the intended action.
AM 1.6	The "Notice of Intended Action" forms use commonly understood language.
AM 1.7	The "Notice of Intended Action" forms use commonly understood language.
AM 3.1	The Program Contractor has assessed the non-English language needs of its limited English proficiency (LEP) membership.
AM 3.2	The Program Contractor translates all written materials for each LEP language group that constitutes 5 percent or 1,000 (whichever is less) of the Program Contractor's membership.
AM 4.1	The Program Contractor has implemented its Cultural Competency Plan.
AM 4.2	The Program Contractor conducted an annual evaluation of its Cultural Competency Plan and a copy of the evaluation was sent to the Division of Health Care Management.
AM 4.3	The Program Contractor has an ongoing education program about providing culturally competent services.
AM 4.4	The Program Contractor has provided cultural competency education to its employees.
AM 4.5	The Program Contractor has taken steps to provide culturally competent services to its members.
AM 10.1	The Program Contractor ensures that routine care PCP appointments are available within 21 days of request.
AM 10.2	The Program Contractor ensures that routine care specialty appointments are available within 30 days of referral.
Behavioral Health	
BH 5.0	The Program Contractor ensures that covered behavioral health services are provided in a timely manner.
Delivery System	
DS 2.2	The Program Contractor assures that a member's waiting time for a scheduled appointment is no more than 45 minutes, except when the provider is unavailable due to an emergency.

Table A-2—Areas of Review *for* Maricopa Long Term Care	
Number	**Description**
Financial Management	
FM 1.1	Monthly, quarterly, and annual financial reports are complete. These reports include complete disclosure on material variances and or significant changes.
FM 1.3	Quarterly and annual financial reports are timely.
Grievance and Appeals	
GA 1.0	The Program Contractor has written policies for: Member Grievances, Member Appeals, Member Expedited Appeals, and Provider grievances.
GA 2.0	The Program Contractor's grievance and appeal decisions are consistent, reliable, and relevant to specific grievance issues.
Quality Management	
QM 2.1	The Contractor must have a system in place for credentialing and recredentialing providers included in its contracted service provider network.
QM 2.2	The Contractor must have written policies that reflect the scope, criteria, timeliness, and process for credentialing and recredentialing practitioners and organizational providers.
QM 3.1	Each Contractor must have a process for reviewing and evaluating complaints and allegations.
QM 4.0	The Quality Management/Quality Improvement (QM/QI) Program must report the performance of the Contractor using standard performance indicators established or adopted by AHCCCS.
QM 5.0	Each Contractor must conduct Quality Improvement Projects (QIPs)/Performance Improvement Projects (PIPs) to assess the quality of its service provision and improve performance.
Utilization Management	
UM 1.1	The Contractor has written policies and procedures for utilization management program requirements that are consistent with AHCCCS standards.
UM 1.2	Mechanisms are in place to identity and address potential under- and over-utilization issues.
UM 1.3	The Contractor has adopted and disseminated practice guidelines.
PA 1.1	The Contractor has a structure and process in place to monitor/evaluate prior authorization services.
PA 1.2	The Contractor makes prior authorization decisions in a timely manner.
PA 1.3	The Contractor monitors summary information that describes the cost and utilization of pharmacy services to allow the Contractor to adequately mange its prescription benefit program.